Medi-Cal Managed Care Division

state of california

Medi-Cal Managed Care
External Quality Review Organization

Report of the

2005 Annual Review
Health Plan San Joaquin

Submitted by
Delmarva Foundation
October 2005

California Department of Health Services

Delmarva Foundation
Improving Healthcare in the Communities We Serve.

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2005 Annual Review: Health Plan of San Joaquin

Introduction

The California Department of Health Services (DHS) is charged with the responsibility of evaluating the quality of care provided to Medi-Cal recipients enrolled in contracted Medi-Cal managed care plans. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DHS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 and federal EQRO regulations, Delmarva has conducted a comprehensive review of Health Plan of San Joaquin to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality**, stated in the federal regulations as it pertains to external quality review, is defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review", 2003).

- **Access** (or accessibility) as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines", 2003).

- **Timeliness** as it relates to Utilization Management (UM) decisions is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines", 2003). An additional definition of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care", 2001).

Although Delmarva's task is to assess how well Health Plan of San Joaquin performs in the areas of quality, access, and timeliness it is important to note the interdependence of quality, access and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access or timeliness may also be noted under either of the two other areas.

Methodology and Data Sources

Delmarva utilized four sets of data to evaluate Health Plan of San Joaquin's (HPSJ) performance. The data sets are as follows:

- 2004 Health Employer Data Information Set (HEDIS) is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). These measures are used by health care purchasers to assess the quality and timeliness of care and service provision to members of managed care delivery systems.
- 2004 Consumer Assessment of Health Plan Satisfaction (CAHPS) Version 3.0H is a nationally employed survey developed by NCQA. It is used to assess managed care members satisfaction with the quality, access and timeliness of care and services offered by managed care organizations. CAHPS offers a standardized methodology that allows potential managed care beneficiaries to compare health plans. This comparison is designed to help the potential beneficiary select a health plan that offers the quality and access to care compatible with their particular preferences.
- Summaries of plan-conducted Quality Improvement Projects (QIPs)
- Division of Health Plan Oversight Medical Audits – conducted by the Department of Managed Health Care (DMHC) Division of Health Plan Oversight to assess compliance with State regulations.

Background on Health Plan of San Joaquin

Health Plan of San Joaquin (HPSJ) is a full service, not for profit health plan contracted in San Joaquin County as a local initiative (LI) plan. The Plan has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since January 30, 1996. As of July, 2003, HPSJ's total Medi-Cal enrollment was 56,394 members.

During the HEDIS reporting year of 2004, Health Plan of San Joaquin collected data related to the following clinical indicators as an assessment of quality:

- Childhood Immunizations
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Use of Appropriate Medications for People with Asthma

To assess member satisfaction with care and services offered by Health Plan of San Joaquin, the CAHPS survey, version 3.0 H was fielded among a random sample of health plan beneficiaries. The survey was administered to adults and parents of children for whom Health Plan of San Joaquin provides insurance coverage. Within the sample of children selected is a subset population of children who are identified as having chronic care needs (CSHCN population). This population differentiation provides regulators and other interested parties an understanding regarding whether children with complex needs experience differences in obtaining care and services compared to children within the Medi-Cal population.

With respect to the Quality Improvement Projects, HPSJ submitted the following for review:

- Adolescent Health Collaborative Project
- Increasing the number of HbA1c tests that each identified diabetic member receives annually 2 screening tests or more
- Increasing the number of Postpartum visits within 21-56 days after delivery
- Immunization Collaborative

The health plan systems review for HPSJ reflects findings assessed by DMHC. This review was conducted July 22-25, 2002. This process includes document review, verification studies, and interviews with HPSJ staff.

These activities assess compliance in the following areas:

- Quality Management
- Access and Availability
- Utilization Management
- Grievance System

Delmarva also reviewed the results of a routine monitoring review conducted by the DHS Medi-Cal Managed Care Division, Plan Monitoring/Member Rights Branch. The focus of this review covers services provided from July-December, 2002, was to assess how well member grievances and prior authorizations are processed

and monitored. Additionally, Delmarva evaluated the cultural and linguistic services offered by HPSJ, as well as its marketing practices.

Quality At A Glance

HEDIS®

The HEDIS areas assessed for clinical quality can be found on page three of this report Table 1. The table below shows the aggregate results obtained by HPSJ.

2004 HEDIS Quality Measure Results for Health Plan of San Joaquin

HEDIS Measure	2004 HPSJ Rate	Medi Cal Managed Care Weighted Average	2004 National Medicaid HEDIS Average
Childhood Immunization Status Combo 1	56.3%	64.7%	61.8%
Breast Cancer Screening	43.2%	53.1%	55.8%
Cervical Cancer Screening	44.9%	60.8%	63.8%
Chlamydia Screening in Women	44.9%	38.5%	45.0%
Use of Appropriate Medications for People with Asthma	59.2%	61.0%	64.2%

HPSJ exceeded the Medi-Cal managed care average for one HEDIS measure and fell below the Medi-Cal managed care average for four HEDIS measures. All five measures fell below the National Medicaid HEDIS average.

CAHPS® 3.0H

As can be expected, Medi-Cal enrollees' perceptions of the quality of care received are closely related to their satisfaction with providers and overall health care services. Therefore, the CAHPS survey also questioned parents of HPSJ's enrollees regarding their satisfaction with care. Also surveyed was a subset of the HPSJ childhood population who has special health care needs. They are reflected by the CSHCN notation in Table 2. The non CSHCN reflects the parents' response for children in the HPSJ population not identified as having chronic care needs.

Table2. 2004 CAHPS Quality Measure Results for Health Plan of San Joaquin

CAHPS Measure	Population	2004 HPSJ Rate	2004 Medi Cal Average
Getting Needed Care	Adult	65%	69%
	Child	77%	77%
	CSHCN	68%	N/A
	Non-CSHCN	79%	N/A
How Well Doctors Communicate	Adult	49%	51%
	Child	57%	52%
	CSHCN	54%	N/A
	Non-CSHCN	57%	N/A

CAHPS data reveals that the perception of getting needed care is more favorable for children as compared to adults. The HPSJ child rate also had the same rate as the Medi-Cal managed care average (77%). Also of note is that parents of children with chronic care conditions (CSHCN) report less satisfaction with "Getting Needed Care" than their Medi-Cal peers. The finding of lower satisfaction with this group highlights the need for HPSJ's practitioner networks to enhance its sensitivity to the needs of this more vulnerable population.

Review of data indicating members' perception of "How Well Doctors Communicate" demonstrates that HPSJ members perceive that there are opportunities for improvement in practitioner communication. The HPSJ child rate for this measure exceeded the Medi-Cal managed care average by several percentage points (57% versus 52%). The finding that parents of the CSHCN population have a different rate of satisfaction with communication as parents of Medi-Cal children (54% versus 57%) leads to the belief that practitioners do differentiate in their communication style between the two groups. Additionally, HPSJ adults are generally less satisfied with the communication skills of practitioners compared to the Medi-Cal managed care average.

Quality Improvement Projects

In the area of Quality Improvement Projects (QIPs), HPSJ used the quality process of identifying a problem relevant to their population, setting a measurement goal, obtaining a baseline measurement and performing targeted interventions aimed at improving the performance. However, after the re-measurement periods, qualitative analyses often identified new barriers that impacted HPSJ's success in achieving its targeted goal. Thus quality improvement is an ever evolving process that may not be actualized due to changes in the study environment from one measurement period to the next.

The quality improvement projects (QIP) performed by HPSJ can be found on page three of this report. The following section provides a synopsis of each QIP undertaken by HPSJ.

Improving Access to Adolescent Well Care Services

Relevance:

- Approximately 26% (15,000) of HPSJ's members are between the ages of 12 - 21. In 2002 HPSJ's HEDIS rate for adolescent well-care visits, 31.05%, was below the national Medicaid average.

Goals:

- To increase the number of adolescents (aged 12-21 years) who have at least one comprehensive well-care visit with a PCP and/or OB/GYN.

Best Interventions:

- Established local referral resources for adolescent care.
- Implemented an educational campaign targeted to adolescents and providers to promote the importance of annual adolescent well care.

Outcomes:

- N/A - This project is a baseline measure.

Attributes/Barriers to Outcomes:

- Barrier: Providers uncomfortable performing screening and counseling with adolescents
- Barrier: Poor provider attendance at educational presentations
- Barrier: Teen perception of [lack of] confidentiality

Increasing the number of HbA1c tests that each identified diabetic member receives annually to 2 or more

Relevance:

- In 2002 only 16.5% of HPSJ's diabetic members had 2 or more HbA1c tests performed during the year.

Goals:

- Improve the rate of members receiving 2 or more HbA1c tests to 50%.

Best Interventions:

- Developed electronic Diabetes Management Tool that prompts providers to perform tests.
- Designated Diabetes Coordinators from provider offices to oversee care of diabetic members.
- Provided diabetes education through provider and member newsletters.

Outcomes: There was minimal baseline improvement from 2002 to 2003. Rates were as follows:

- 2002: 16.5%
- 2003: 16.8%

Attributes/Barriers to Outcomes:

- Barrier: Lack of diabetic care coordination.
- Barrier: Lack of system to track tests received by diabetic members.

Increasing the number of Postpartum visits within 21 - 56 days of delivery

Relevance:

- HPSJ has a historically low HEDIS postpartum visit rate.

Goals:

- To meet or exceed NCQA's 90th percentile benchmark for postpartum visits - 67.4%.

Best Interventions:

- Provide financial incentives to members who receive postpartum visits within the specified number of days.
- Mailing educational materials to members after delivery focusing on the importance of postpartum visits.
- Calls made by advice nurses to women following delivery to emphasize the importance of postpartum visits.

Outcomes:

- N/A – HEDIS rates had not been validated, so results were not reported by HPSJ.

Attributes/Barriers to Outcomes:

- Provider offices do not have tracking systems to ensure women are seen for postpartum visits.
- Members do not schedule or keep postpartum appointments if they are feeling fine after delivery

Immunization Collaborative

Relevance:

- Recognition of the need for timely immunizations for children.

Goals:

- Continued improvement and focused activities to increase the immunization rate.

Best Interventions:

- Identified providers accounting for high volumes of childhood immunizations.
- Recruited providers to participate in the immunization project through financial incentives and educational activities.
- Established working relationships with immunization registries.

Outcomes:

- HEDIS 2003 Immunization Rate:
  - Combo 1 = 58.29%,
  - Combo 2 = 53.86%

Attributes / Barriers to Outcomes:

- HPSJ reported difficulty working with other managed care organizations in the collaborative.
- HPSJ underwent major IS system changes that created delays in compiling data.

Table 3 represents the Qualitative Results of each QIP.

Table 3: Quality Improvement Project Performance Results- HPSJ

Health Plan	QIP Activity	Indicator	Baseline	Re measurement		
				#1	#2	#3
Health Plan of San Joaquin	Adolescent Health Collaborative	Rate of members who received an Adolescent Well Care Visit	2004 Not reported			
	Increasing the number of HbA1c tests that each identified diabetic member receives annually to 2 or more	Rate of members who received 2 or more HbA1c tests during the reporting year	2002 16.5%	2003 16.8%		
	Increasing postpartum visits	Percentage of women who had a postpartum visit within 21 – 56 days of delivery	1999 – 2003 45.02% (HEDIS average)			
	Immunization Collaborative	HEDIS Combo 1 rate (4 DtaP, 3 OPV/IMV; 2 HIB; 1 MMR; 3 Hepatitis B; 1 Varicella) HEDIS Combo 2 (All of the above except Varicella)	2003 56.3% 53.86%			

Health Plan Oversight Review Findings

Delmarva reviewed the results of the medical audit performed by DMHC. Within the health plan oversight component of the quality review, the following review requirements were identified by DMHC as in need of improvement:

Quality Management

- Oversight of Delegated Entities

Grievance and Appeals

- Governing Body Review Requirements

To address these opportunities, DMHC conducted active oversight of HPSJ's corrective action process. HPSJ implemented recommendations to correct identified opportunities related to Quality Review Requirements.

Summary of Quality

In summary, HPSJ Health Plan demonstrates a quality-focused approach in administering care and services to its members. The plan demonstrates an integrated approach to working with its members, practitioners, providers and the internal health plan departments to improve overall healthcare quality and services.

Access At A Glance

Access to care and services has historically been a challenge for Medi-Cal recipients enrolled in fee-for-service programs. One of the Medi-Cal Managed Care Division's (MMCD) goals is to adequately protect enrollee access to care. Access is an essential component of a quality-driven system of care. The findings in regards to access are displayed in the following sections.

HEDIS®

Looking at access from a HEDIS perspective, access and availability of care are addressed through the Prenatal and Postpartum Care HEDIS measures. Two rates are calculated for this measure, the timeliness of prenatal care and the completion of a postpartum check-up following delivery.

Table 4: 2004 HEDIS Access Measure Results for Health Plan of San Joaquin

HEDIS Measure	2004 HPSJ Rate	Medi Cal Managed Care Weighted Average	2004 National Medicaid HEDIS Average
Timeliness of Prenatal Care	69.0%	75.7%	76.0%
Postpartum Check-up Following Delivery	60.2%	55.7%	55.2%

HPSJ scored above the Medi-Cal managed care average and the National Medicaid HEDIS average for the "Postpartum Check-up Following Delivery" rate and below the comparison averages for "Timeliness of Prenatal Care". Postpartum care is impacted by the health plan's access to correct demographic information for outreach to postpartum members. These results demonstrate that there is potential for improvement pertaining to access.

CAHPS®

Member satisfaction scores related to access to services are addressed in a composite rating calculated as part of the CAHPS survey. This composite rating for "Getting Care Quickly" is used as a proxy measure for access and availability.

Table 5. 2004 CAHPS Access Measure Results for Health Plan of San Joaquin

CAHPS Measure	Population	2004 HPSJ Rate	Medi Cal Managed Care Average
Getting Care Quickly	Adult	32%	35%
	Child	41%	38%
	CSHCN	37%	N/A
	Non-CSHCN	41%	N/A

Findings from 2004 indicate that HPSJ scored above the Medi-Cal managed care average for children in this measure and scored below the average for adults. However of greater importance is the fact that children with chronic care needs (CSHCN) have slightly less satisfaction with access than HPSJ's Medi-Cal children's population. When considered with the CAHPS quality assessment for getting care when needed, one can deduce that the complex care population is less satisfied with their ability to obtain routine care and when they perceive a more urgent need, they are not necessarily better able to obtain care compatible with their

expectations. We can infer from these results that there may be opportunity for improvement pertaining to this measure in the area of access.

Quality Improvement Projects

Health Plan of San Joaquin's quality improvement projects all focused upon improvement of clinical indicators. However, within the barrier analyses for each project, potential access barriers were frequently identified. The identification of these access barriers is followed by interventions targeted to improve access. Several of the QIP activities identified access as a barrier in the performance of the qualitative analysis of their projects. Actions were then taken to ameliorate or when possible, eliminate the identified access barrier. For examples of access barriers identified, refer to the quality section discussion of QIP activities: attributes/barriers to outcomes.

Health Plan Oversight Review Findings

Delmarva reviewed the results of the medical audit performed by DMHC. This audit covered health plan activity from 2002 and encompassed a compliance review considering requirements which represent proxy measures for access. The following review requirements were identified by DMHC as in need of improvement:

- Availability and Access
  - Monitoring and Evaluation

To address these opportunities, DMHC conducted oversight of HPSJ's corrective action process. HPSJ implemented recommendations related to Access Review Requirements to correct identified opportunities.

Summary of Access

Overall, access is an area where continued work towards improvement occurs. Performance above the Medi-Cal average in the areas of postpartum care and Childhood "Getting Care Quickly" demonstrate HPSJ's efforts towards improving access. Combining all the data sources used to assess access, HPSJ has addressed the monitoring and evaluation of access which was identified as an area for improvement during the A&I audit. HPSJ corrected issues related to monitoring and evaluation of access in order to comply with the access standards required by DHS/DMHC.

Timeliness At A Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medi-Cal managed care enrollees. Equally important is the timely delivery of those services. The findings related to timeliness are revealed in the sections to follow.

HEDIS®

Timeliness of care is assessed using the results of the HEDIS Adolescent Well Care Visits and Well Child Visits in the First 15 Months of Life, as well as the DHS developed Blood Lead Level Testing measure. All Medi-Cal managed care plans were required to submit these measures.

Table 6: 2004 HEDIS Timeliness Measure Results for Health Plan of San Joaquin

HEDIS Measure	2004 HPSJ Rate	Medi Cal Managed Care Weighted Average	2004 National Medicaid HEDIS Average
Well Child Visits in the First 15 Months of Life - 6 or more visits	38.9%	48.7%	45.3%
Adolescent Well-Care Visits	38.0%	33.9%	37.4%
Follow-Up Rate for Children with elevated BLL at 24 Months	10.0%	53.7%	N/A
Follow-Up Rate for Children with elevated BLL at 27 Months	N/A	33.1%	N/A

The "Well Child Visits in the First 15 Months of Life" measure fell below both the Medi-Cal managed care average and the National Medicaid HEDIS average. However, the "Adolescent Well-Care Visits" measure exceeded both comparison averages. When looking at this data compared to the HEDIS childhood immunization results for Contra Costa Health Plan, it is explicable that the rates are found to be low for both measures (Childhood Immunization Status and Well Child Visits in the First 15 Months of Life or 6 or more visits). This may indicate that if practitioners performed more well child visits, the childhood immunization rates may be higher. These results may reveal opportunities for improvement in the area of timeliness.

CAHPS®

Member satisfaction scores related to timeliness of services are addressed in two composite ratings calculated as part of the CAHPS survey: Courteous and Helpful Office Staff and Health Plan's Customer Service.

Table 7. 2004 CAHPS Timeliness Measure Results for Health Plan of San Joaquin

CAHPS Measure	Population	2004 HPSJ Rate	2004 Medi Cal Average
Courteous and Helpful Office Staff	Adult	52%	54%
	Child	60%	53%
	CSHCN	59%	N/A
	Non-CSHCN	61%	N/A
Health Plan's Customer Service	Adult	65%	70%
	Child	79%	79%
	CSHCN	70%	N/A
	Non-CSHCN	79%	N/A

Members' perception of courteous and helpful office staff generally impacts utilization of services. HPSJ adult members find office staff less helpful when compared to the general Medi-Cal population. This could explain the reason that HPSJ scored below the Medi-Cal average in four of the five (80%) HEDIS quality measures. However, the HPSJ child rate for this measure exceeded the Medi-Cal average (60% versus 53%). If staff is not perceived helpful or courteous, members may not feel able to get information needed to obtain care. It is noteworthy that parents of children with chronic care needs find office staff slightly less courteous and helpful than parents of Medi-Cal children without chronic care needs. This is important as this population often requires more guidance from office staff in order to avoid crisis care management. HPSJ adult members generally find health plan customer services staff less helpful than the child and CSHCN population. This may be explainable due to the fact the CSHCN population are likely to require more information related to direct medical care. This information is likely to be better provided by the medical office staff.

Quality Improvement Projects

Timeliness was a focal area of attention in most of the QIPs**.** Member-focused efforts consisted of assuring that members were reminded of preventive services prior to the age range when the services are due. HPSJ used a variety of mechanisms to address timeliness, including sending birthday card reminder, disseminating preventive health guidelines to members and clinicians and providing evidence-based literature to the practitioner network. Practitioner barriers related to timeliness issues focus upon the lack of timely provision of care or services due to missed opportunities.

Issues related to timeliness of services may very likely be impacted by access. HPSJ acknowledged the relationship between timeliness and access within the barrier analysis of the QIP where access was often identified as a barrier. If care or service cannot be obtained, timely provision of the needed service is unlikely. The interdependence of access and timeliness is further illustrated in QIP studies that are HEDIS-related and focus upon services received (access) as well as the timeframe in which the service was provided (timeliness).

Health Plan Oversight Review Findings

Delmarva's review of DMHC's plan survey activity from 2002 evidenced that the review requirements monitored reflect adequate proxy measures for timeliness. The following review requirements were identified by DMHC as in need of improvement:

Utilization Management

- Communication to Enrollees of UM Processes
- Independent Medical Review
- Non-Authorization Timeliness Requirements
- Denial Letter Requirements

Grievance and Appeals

- Grievance Acknowledgement Requirements

To address these opportunities, DMHC conducted oversight of HPSJ's corrective action process. HPSJ implemented recommendations related to Timeliness Review Requirements to correct identified opportunities

Summary for Timeliness

Timeliness barriers are often identified as access issues. HPSJ addressed timeliness in many of the QIPs. Each HEDIS quality measure combines the receipt of the service with the timeframe for provision of the service. Both elements must be met to achieve compliance. Since most of the QIPs focus upon HEDIS-related topics and methodology, HPSJ demonstrates an awareness of the importance of timeliness in the provision of overall quality care and service.

Overall Strengths

Quality:

- Commitment of HPSJ management staff towards quality improvement as evidenced by the rapid response and resolution of the deficiencies cited during the audit and investigation reviews.
- General precise documentation within the QIP that defines the problem under study, indicator measures and the tri-focal approach to interventions taken to attain improvement followed by reassessment for improvement.

Access:

- HPSJ scored above the Medi-Cal and national Medicaid average for postpartum exam after delivery.

- HPSJ achieved greater satisfaction among parents with the perception of getting care quickly for children in comparison to the Medi-Cal population in general.

Timeliness:

- HPSJ exceeded both the Medi-Cal average and the national Medicaid average for adolescent well care rates.
- HPSJ's recognition of the interdependence of access and timeliness for improvement of care and/or services to be realized.

Recommendations

- Conduct follow-up assessments of the perception of the intended audience receiving educational endeavors. Follow-up with practitioners and/or members to determine if educational materials were effective towards attaining the desired behavior or outcome helps to assess the effectiveness of the activity.
- Perform periodic monitoring within areas identified in the medical audit as deficient to make certain that the actions undertaken to correct the issues remain effective.
- Perform further investigation of low satisfaction areas identified by CAHPS.
- Assess the disparities in quality of care and/or services among differing ethnic populations within the managed care membership. Understanding this phenomenon will enable focused resource allocation.
- Perform interventions such as random sample surveys to understand if members perceptions of their ability to access care when needed has an impact upon the actual receipt of timely care or service.
- Coordinate activities between quality and provider relations staff to enhance the likelihood of compliance with timeliness standards.

Recommendations that have been implemented independent of the EQRO feedback should be viewed as information only and be continually monitored by the health plan for assessment of improvement to be included in next year's plan specific report.

References:

California Department of Health Care Services, Medi-Cal Program. (2003). *External Quality Review Organization Contract- Delmarva Foundation for Medical Care, Inc., Exhibit A, Attachment I- Detailed Scope of Work, 03-75611.*

California Department of Health Services, Medical Care Statistics Section. (2004, August). *Interim Managed Care Annual Statistical Report.* Retrieved November 18, 2004, from California Department of Health Services website: www.dhs.ca.gov/mcss/PublishedReports/annual/managed_care/mcannual04/04report.htm

California Department of Health Care Services, Medi-Cal Program. (2004, December). *Medical Services Provider Manual, Part 1- Medi-Cal Program and Eligibility, Medi-Cal Program Description.* Retrieved November 1, 2004, from California Department of Health Services website: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/00medi-cal_z00.doc

Centers for Medicare and Medicaid Services (CMS). (2002, June). *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et.al. Subpart D- Quality Assessment and Performance Improvement*. Retrieved December 9, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

Centers for Medicare and Medicaid Services (CMS). (2003, January). *Final Rule: External Quality Review of Managed Care Organizations and Prepaid Inpatient Health Plans; 42 CFR Part 438.300 et.al.* Retrieved November 1, 2004 from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf

Institute of Medicine (IOM), Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report.* Retrieved February 24, 2005, from the National Academies Press website: http://www.nap.edu/html/envisioning/ch2.htm

National Committee for Quality Assurance (NCQA). (2003). *Standards and Guidelines for the Accreditation of MCOs.*